



WELL CHILD EXAM - INFANCY: 6 MONTHS

(Meets EPSDT Guidelines)

DATE

ການກວດສອບ – ໂວດັກບັນຕົ້ນ: 6 ເດືອນ

ໝາຍເມັນຫຼັງປະກອບເຫດຜູ້ຈຸດ ກຽງວັນຜົນຫຼັງປະກອບເຫດຜູ້ຈຸດ	ຊື່ດັກ	ນຳເອົາມາໄດ້ຍ:	ວັນທີດັກ																																			
	ອາການຜິດ		ຢາກທີ່ຂັ້ງຢູ່ໃນປະຈຸບັນ																																			
	ອາການເຈັບເປັນ/ອຸປະຕິເຫດ/ຫັນຫາ/ສຶກກົງວິນ ນັບແຕ່ມາເຖີ່ງສຸດທ້າຍ			ມັນວັນພະເຈົ້າມີຄໍາຖານກ່ຽວກັບເຮື່ອງ:																																		
	<p>ແມ່ນ ບໍ່ <input type="checkbox"/> <input type="checkbox"/> ເດັກຂອງຂອບຍົນອາຫານແນວເປັນຕ່ອນບາງແນວໄດ້. <input type="checkbox"/> <input type="checkbox"/> ເດັກຂອງຂອບເລົາບາງສຶກ ແຊ່ນວ່າ "ດາດາ" ຫີ້ "ບາບາ". <input type="checkbox"/> <input type="checkbox"/> ເດັກນ້ອຍຂອງຂອບນັ້ນດັກວິການຊ່ວຍໄຈໄວ. <input type="checkbox"/> <input type="checkbox"/> ຂອບບໍ່ກົງວິນທີ່ຂອບມີອາການເສົ້າເລື້ອຍໆ.</p>																																					
WEIGHT KG./OZ. PERCENTILE	HEIGHT CM/IN. PERCENTILE	HEAD CIR. PERCENTILE	Diet _____ Elimination _____ Sleep _____																																			
<input type="checkbox"/> Review of systems <input type="checkbox"/> Review of family history		<input type="checkbox"/> Review Immunization Record <input type="checkbox"/> Lead exposure <input type="checkbox"/> Fluoride Supplements <input type="checkbox"/> Fluoride Varnish <input type="checkbox"/> Hct/Hgb Health Education: (Check all discussed/handouts given) <input type="checkbox"/> Family Planning <input type="checkbox"/> Safety <input type="checkbox"/> Infant Temperament <input type="checkbox"/> Development <input type="checkbox"/> Crib Safety <input type="checkbox"/> Shaken Baby Syndrome <input type="checkbox"/> No Bottle in Bed <input type="checkbox"/> Feeding <input type="checkbox"/> Fever <input type="checkbox"/> Teething/Dental <input type="checkbox"/> Bedtime ritual <input type="checkbox"/> Language Stimulation <input type="checkbox"/> Stranger Anxiety <input type="checkbox"/> Appropriate Car Seat <input type="checkbox"/> Child care <input type="checkbox"/> Passive Smoke <input type="checkbox"/> Other: _____																																				
<p>Screening:</p> <table style="margin-left: auto; margin-right: auto;"> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Hearing</td> <td>Vision</td> </tr> </table> <p>Development: Circle area of concern</p> <table style="margin-left: auto; margin-right: auto;"> <tr> <td>Adaptive/Cognitive</td> <td>Language/Communication</td> </tr> <tr> <td>Gross Motor</td> <td>Social/Emotional</td> </tr> <tr> <td>Fine Motor</td> <td></td> </tr> <tr> <td>Behavior</td> <td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Mental Health</td> <td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Physical:</td> <td>N A</td> </tr> <tr> <td>General appearance</td> <td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Skin</td> <td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Head/Fontanelle</td> <td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Eyes (Cover/Uncover)</td> <td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Ears</td> <td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Nose</td> <td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Oropharynx</td> <td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Neck</td> <td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Nodes</td> <td><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table> <p>Chest N A</p> <p>Lungs N A</p> <p>Cardiovascular/Pulses N A</p> <p>Abdomen N A</p> <p>Genitalia N A</p> <p>Spine N A</p> <p>Extremities N A</p> <p>Neurologic N A</p>					<input type="checkbox"/>	<input type="checkbox"/>	Hearing	Vision	Adaptive/Cognitive	Language/Communication	Gross Motor	Social/Emotional	Fine Motor		Behavior	<input type="checkbox"/> <input type="checkbox"/>	Mental Health	<input type="checkbox"/> <input type="checkbox"/>	Physical:	N A	General appearance	<input type="checkbox"/> <input type="checkbox"/>	Skin	<input type="checkbox"/> <input type="checkbox"/>	Head/Fontanelle	<input type="checkbox"/> <input type="checkbox"/>	Eyes (Cover/Uncover)	<input type="checkbox"/> <input type="checkbox"/>	Ears	<input type="checkbox"/> <input type="checkbox"/>	Nose	<input type="checkbox"/> <input type="checkbox"/>	Oropharynx	<input type="checkbox"/> <input type="checkbox"/>	Neck	<input type="checkbox"/> <input type="checkbox"/>	Nodes	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>																																					
Hearing	Vision																																					
Adaptive/Cognitive	Language/Communication																																					
Gross Motor	Social/Emotional																																					
Fine Motor																																						
Behavior	<input type="checkbox"/> <input type="checkbox"/>																																					
Mental Health	<input type="checkbox"/> <input type="checkbox"/>																																					
Physical:	N A																																					
General appearance	<input type="checkbox"/> <input type="checkbox"/>																																					
Skin	<input type="checkbox"/> <input type="checkbox"/>																																					
Head/Fontanelle	<input type="checkbox"/> <input type="checkbox"/>																																					
Eyes (Cover/Uncover)	<input type="checkbox"/> <input type="checkbox"/>																																					
Ears	<input type="checkbox"/> <input type="checkbox"/>																																					
Nose	<input type="checkbox"/> <input type="checkbox"/>																																					
Oropharynx	<input type="checkbox"/> <input type="checkbox"/>																																					
Neck	<input type="checkbox"/> <input type="checkbox"/>																																					
Nodes	<input type="checkbox"/> <input type="checkbox"/>																																					
<p>Describe abnormal findings and comments:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>																																						
<p style="text-align: center;">IMMUNIZATIONS GIVEN</p> <p>_____</p> <p>_____</p> <p>_____</p>																																						
<p style="text-align: center;">REFERRALS</p> <p>_____</p> <p>_____</p> <p>_____</p>																																						
NEXT VISIT: 9 MONTHS OF AGE		HEALTH PROVIDER NAME																																				
HEALTH PROVIDER SIGNATURE		HEALTH PROVIDER ADDRESS																																				

Guidance to Physicians and Nurse Practitioners for Infancy (6 months)

The following highlight EPSDT screens where practitioners often have questions. They are not comprehensive guidelines.

Fluoride Screen

Look for white spots or decay on teeth. Check for history of decay in family. Fluoride supplements should be considered for all children drinking fluoride deficient (<0.6 ppm F) water. Before supplements are prescribed, it is essential to know the fluoride concentration of the patient's drinking water. Once the fluoride level of the water supply has been evaluated, either through contacting the public health officials or water analysis, as well as evaluating other sources of fluoride, the daily dosage schedule can be recommended. Pediatric Dentistry: Reference Manual 1999--00.(215).

Hearing Screen

Use clinical judgment.

Lead Screen

Screen infants for these risk factors:

- Live in or frequently visit day care center, preschool, baby sitter's home or other structure built before 1950 that is dilapidated or being renovated.
- Come in contact with other children with known lead toxicity (i.e., blood lead 15ug/dl).
- Live near a lead processing plant or with parents or household members who work in a lead-related occupation (e.g., battery recycling plant).

Developmental Milestones

Always ask about and follow-up on parent concerns about development or behavior. You may use the following screening list, or use the Ages and Stages Questionnaire, the Denver II, the ELMS2 (a language screen), or the MacArthur Communication Development Inventory.

Yes	No	Yes	No		
<input type="checkbox"/>	<input type="checkbox"/>	<u>No head lag when pulled to sit.</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Turns toward voice.</u>
<input type="checkbox"/>	<input type="checkbox"/>	<u>Bears some weight on legs when held.</u>	<input type="checkbox"/>	<input type="checkbox"/>	Transfer object from hand to hand.
<input type="checkbox"/>	<input type="checkbox"/>	<u>Rolls over.</u>	<input type="checkbox"/>	<input type="checkbox"/>	Cuddles.
<input type="checkbox"/>	<input type="checkbox"/>	Imitates speech sounds.			Avoids eye contact.

Instructions for developmental milestones: At least 90% of infants should achieve the underlined milestones by this age. If you have checked "no" on any two items, or even one of the underlined items, or the boxed item, refer the infant for a formal developmental assessment.

Notes: Immunization schedules are from the Advisory Committee on Immunization Practice of the U.S. Centers for Disease Control and Prevention. **Parents and providers may call Healthy Mothers, Healthy Babies (1-800-322-2588) with questions or concerns on childhood development.**



ການກວດເຕັກໃຫ້ມີສຸຂພາບດີ - ແອນັ້ນຍິນ: 6 ເດືອນ

WELL CHILD EXAM - INFANCY: 6 MONTHS
(ແຮດຕາມຄໍາຊັ້ນນຳ EPSDT)

ວັນທີ

ການກວດສອບ - ໄວດັກບັນຕົ້ນ: 6 ເດືອນ

ປ່ານປັ້ງປັບປຸງການເຫັນສອງຈາກ	ຊື່ເຕັກ	ນໍາເຂົ້າມາໄດ້ຍິນ:	ວັນເກີດ
	ອາການຜິດ	ຢາກທີ່ຂັ້ນຢູ່ໃນປະຈຸບັນ	
	ອາການເຈັບເປັນ/ອຸປະຕິເຫດ/ຫັນຫາ/ສຶກກົງວິນ ນັບແຕ່ມາເຖີ່ອສຸດທ້າຍ	ມັນໜີ້ຂ້າພະເຈົ້າມີຄໍາຖານກ່ຽວກັບເຮືອງ:	
	<p>ແມ່ນ ບໍ່ <input type="checkbox"/> <input type="checkbox"/> ເຕັກຂອງຂອບກິນອາຫານແນວເປັນຕ່ອນບາງແນວໄດ້. <input type="checkbox"/> <input type="checkbox"/> ເຕັກຂອງຂອບເວົ້າບາງສຶກ ແຊ່ນວ່າ "ດາດາ" ຫລື "ບາບາ". <input type="checkbox"/> <input type="checkbox"/> ເຕັກນີ້ຂອງຂອບນີ້ດັບການຊ່ວຍໄກຈະໄວ. <input type="checkbox"/> <input type="checkbox"/> ຂອບບໍ່ກົງວິນທີ່ຂອບມີອາການເຈົ້າເລື້ອຍໆ.</p>		<p>ແມ່ນ ບໍ່ <input type="checkbox"/> <input type="checkbox"/> ເຕັກຂອງຂອບສາມາດຈັບເອົາສຶກຂອງ. <input type="checkbox"/> <input type="checkbox"/> ເຕັກຂອງຂອບປາກິດວ່າຕີໃຈ. <input type="checkbox"/> <input type="checkbox"/> ເຕັກນີ້ຂອງຂອບຈີ້ຂອບ.</p>
ນັ້ນໜັກ KG./OZ. ຕໍ່ຮ້ອຍ	ສຸກ CM/IN. ຕໍ່ຮ້ອຍ	ຂາມດຂອງຫົວ ຕໍ່ຮ້ອຍ	<p>ອາຫານ _____</p> <p>ການຖ່າຍ _____</p> <p>ການນອນ _____</p> <p><input type="checkbox"/> ກວດເບື້ງບັນທຶກສັກປາກັນໄໂຮກ <input type="checkbox"/> ຖືກຜົວພັນກັບສານຂັ້ງກີ</p> <p><input type="checkbox"/> ເຜີ່ມຫາດ ຝີຣີໂຣດ໌ <input type="checkbox"/> ເຄືອບດ້ວຍຫາດ ຝີຣີໄຣດ໌ <input type="checkbox"/> Hct/Hgb</p> <p>ການສຶກສາສຸຂພາບ: (ໝາຍທຸກປ່າຍທີ່ໄດ້ປຶກສາກັນ/ອືອີໃບວ່າວ້ຳມູນຕ່າງໆໃຫ້)</p> <p><input type="checkbox"/> ການວາງແຜນຄອບຄົວ <input type="checkbox"/> ຄວາມປອດໄພ <input type="checkbox"/> ອາຣົມເຕັກນັ້ນຍ</p> <p><input type="checkbox"/> ການພັດທະນາ <input type="checkbox"/> ຕຽງນອນທີ່ປອດໄພ <input type="checkbox"/> ອາການເຕັກສັ້ນ</p> <p><input type="checkbox"/> ບໍ່ກິນນີ້ໃນຕຽງນອນ <input type="checkbox"/> ຊອນອາຫານ <input type="checkbox"/> ເປັນໄວ້</p> <p><input type="checkbox"/> ແຫວ່ງປົງການປົວແຂວງ <input type="checkbox"/> ເວລານອນ</p> <p><input type="checkbox"/> ການກະຕຸ້ນພາສາ <input type="checkbox"/> ໝູດໝັດຄົນຕາງໜ້າ</p> <p><input type="checkbox"/> ເບາະນັ່ງຮົດທີ່ແໜ່ງສົມ <input type="checkbox"/> ການລ້ຽງເດັກ <input type="checkbox"/> ສູບປາແບບບໍ່ຕັ້ງໃຈ</p> <p><input type="checkbox"/> ອື່ນໆ: _____</p> <p>ການປະເມີນ/ແຜນການ: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>ການສັກປາກັນທີ່ໃຫ້</p> <p>ການສຶກຕໍ່</p> <p>ມາພົບທີ່ອໜ້າ: ອາຍຸ 9 ເດືອນ</p> <p>ຂຶ້ຜູ້ຢືນປົວສຸຂພາບ</p> <p>ລາຍເຊັນຜູ້ໃຫ້ການປິດປົວສຸຂພາບ</p> <p>ບໍ່ອນຢູ່ຜູ້ຢືນປົວສຸພາບ</p> <p><input type="checkbox"/> ເບິ່ງຕາມຈົດຕາມຄໍາເວົ້າ</p>

